MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

April 26, 2016

[redacted]

IBR Case Number:	CB16-0000540	Date of Injury:	07/14/2011
Claim Number:	[redacted]	Application Received:	04/04/2016
Claims Administrator:	[redacted]		
Date(s) of service:	08/28/2015 – 08/28/2015		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	G6045, G6045, G6046, and G6056		

Dear [redacted]:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. MAXIMUS Federal Services has determined that no reimbursement is warranted. The Claims Administrator's determination is upheld and the Claim Administrator does not owe the Provider additional reimbursement. A detailed explanation of the decision is provided later in this letter.

The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

[redacted], M.D., M.P.H.
Medical Director

Cc: [redacted]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- OMFS

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE**: **Provider seeking remuneration for G6041, G6045, G6046, and G6056 performed on 08/28/2015.**
- EORs indicate services denied as "included" in the value of another services performed on the same day.
    - EORs and original billing reflecting procedure referred to by the Claims Administrator not submitted for IBR.
- IBR documentation includes a letter from the Provider's Billing Representative with an explanation as to the medical necessity for reported HCPCS G6041, G6045, G6046, and G6056.
- **Administrative Rules § 9792.6.** Utilization Review Standards – Definition (a) "Authorization" means assurance that appropriate reimbursement will be made for an approved specific course of proposed medical treatment to cure or relieve the effects of the industrial injury pursuant to section 4600 of the Labor Code, subject to the provisions of section 5402 of the Labor Code, based on either a completed "Request for Authorization," DWC Form RFA, as contained in California Code of Regulations, title 8, section 9785.5, or a request for authorization of medical treatment accepted as complete by the claims administrator under section 9792.9.1(c)(2), that has been transmitted by the treating physician to the claims administrator. Authorization shall be given pursuant to the timeframe, procedure, and notice requirements of California Code of Regulations, title 8, section 9792.9.1, and may be provided by utilizing the indicated response section of the "Request for Authorization," DWC Form RFA if that form was initially submitted by the treating physician.
- Authorization from the Claims Administrator approving the specific course of treatment relating to G6041, G6045, G6046, and G6056 was not submitted for IBR.
- Authorization for G6041, G6045, G6046, and G6056 services is required for reimbursement; IBR unable to determine medical necessity.
- EORs and original billing reflecting "bundled" procedure referred to by the Claims Administrator not submitted for review of potential edits.
- **Based on the aforementioned documentation and guidelines, reimbursement for G6041, G6045, G6046, and G6056 is not indicated.**

The table on page 4 describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: G6041, G6045, G6046, and G6056

Date of Service: 08/28/2015 Laboratory Services						
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
G0641 G6045, G6046, and G6056	$185.12	$0.00	$156.49	1	$0.00	**Refer to Analysis**

[redacted]

[redacted]

[redacted]